Nursing faculty teaching resource

INSTRUCTOR GUIDE

Run the activity

Guided brief | Cooperative receiver. Handoff at 7:00 p.m.

> **Teaching focus**
>
> Transfer a pending task with an owner and time. Introductory practice for learners with basic postoperative assessment knowledge; use the nurses' station setting.

The brief hints that a task remains due; the worksheet supplies SBAR prompts.

Learning objectives

- Select relevant information and distinguish findings from assumptions.
- Communicate the pending action, owner, time, and supplied contingency.
- Invite clarification and obtain confirmation that the plan is understood.

Suggested timing: about 20 minutes

Time	Activity
3 minutes	Prebrief and calibration; allow longer on first use.
4 minutes	Nurse reads chart; receiver and observer prepare separately.
3 minutes	First handoff.
6 minutes	Reflection, evidence, documentation and debrief.
3 minutes	Same learner repeats the same version.
1 minute	Name an improvement and next target.

Print for your session

For 24 students in 8 groups: 8 outgoing handouts, 8 sets of receiver/observer materials (3 pages per set; 24 single-sided sheets), and 1 guide per facilitator. Receiver: page 1. Observer: pages 2-3. Three rotations need 24 nurse handouts and 24 observer worksheets (page 3); reuse the cards and references.

Facilitation

The suggested timing is a starting point; adjust it for your group. Space groups so reports can be heard and agree how to request faculty help; stagger rounds if needed. Review the facts before teaching and keep answers with faculty. For bedside report, use the companion guide.

Written for US practice settings; adapt terms and policies for your setting.

Fictional scenario for formative communication practice. Not clinical guidance or a validated assessment. Confirm the facts and care plan against your local policy before teaching.

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FACILITATOR AND OBSERVER PREPARATION

Prebrief and observation

Read aloud: a short prebrief

“This is formative practice, not a graded assessment. We will discuss the words heard, then repeat the conversation with the same nurse learner. Equivalent wording is welcome.”

“Our goal is a focused handoff that keeps care safe across the shift change. Two chairs represent the nurses’ station.”

“The patient and chart are fictional. Work with the supplied facts as if they were real, and tell us if something prevents you from doing that. Everyone brings useful experience and is here to learn.”

“Treat one another respectfully. The receiver has a scripted role; resistance is part of the activity, not a judgment of the learner. Anyone may say pause. We will clarify the task, support the learner, and restart if needed. Keep identifiable comments within the learning group.”

“This is a focused report at the nurses’ station, not a complete bedside report. Use the supplied chart and care plan.”

“If information is missing, say it is not provided and explain what you would check. Do not invent a new result, order, or patient response. The receiver should answer ‘That information is not provided.’ Faculty will clarify anything needed to continue.”

“The observer records all marks and prompts, using the reference to check facts and noting brief exact words. The receiver follows the role card and helps clarify what was said during debrief. Start with the learner’s view, then offer evidence and one useful next step.”

Observer only: calibrate privately before starting

Mark O when the behavior is observed and N when it is not yet demonstrated as described. Record any missing parts in the evidence notes; there is no partial category. Use N/A only when there was no scripted opportunity, and explain why. Mark a prompt when someone supplied a missing cue or suggested answer. A scripted challenge or request to repeat an unclear word is not a prompt. Do not total the marks or assign a pass score.

Focus detailed notes on one or two behaviors. For a row with several parts, mark N if a part is missing, then record what was present and what remains. Faculty resolve uncertain marks from the words heard. Binary marks keep feedback simple and consistent with the companion guide; this case checklist is not the validated SBAR-LA rubric.

Example

“Dana Whitfield will reassess” establishes an owner but no time: mark the owner row O and timing row N. Note “owner named; time missing.” “The pain is better” has no supporting reassessment.

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MODEL RESPONSE AND RATIONALE

One possible SBAR

One acceptable response, not a script to memorize. Equivalent wording and a different sensible order are acceptable when meaning and responsibility remain clear.

S Establish the patient and the task

Dana Whitfield, this is Casey Nolan, RN, giving report on Diane Foster, MRN 730516, in room 521. This is postoperative day 1 after a laparoscopic cholecystectomy. The next item due is a pain reassessment at 7:15 p.m.

Why it works: Uses two patient identifiers and leads with a priority that crosses the shift change.

B Select relevant background

The patient remains for observation after postoperative nausea and limited intake. There is a history of hypertension, no known medication allergies, and full-code status. Acetaminophen 650 mg orally was given at 6:15 p.m. under the existing order.

Why it works: Includes the medication and timing so the receiving nurse knows its effect still needs evaluation.

A Separate observation from assumption

At 6:15 p.m., the patient was alert, with no nausea or dizziness, clean dry incisions and reassuring recorded vital signs. Pain was 4 out of 10 with movement. Relief after acetaminophen has not been confirmed. Reassess pain and check safe mobility rather than assume improvement.

Why it works: Interprets the earlier findings and the remaining uncertainty without inventing a medication response.

R Transfer an actionable plan

Can you reassess pain at 7:15 p.m. and document the response? The goal is 3/10 or less. Provide one-person assistance to the bathroom when requested, checking pain and dizziness before standing. If pain remains above goal, reassess and contact the covering surgical clinician to review the plan. Promptly report new or increasing abdominal pain, fever, vomiting or changed vital signs; use the emergency pathway for deterioration. Please confirm the plan and timing. What questions do you have?

Why it works: Connects action, owner, time, mobility safety, and the supplied contingency; acceptance must be confirmed.

> **Receiver confirmation**
>
> I'll reassess pain at 7:15 p.m. and document the response. I'll provide one-person assistance to the bathroom when requested, checking pain and dizziness first. If pain remains above the goal of 3/10, I'll reassess and contact the covering surgical clinician; I'll report new concerning symptoms promptly and use the emergency pathway for deterioration.

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FACILITATION NOTES

Debrief and try again

Start with the learner

- What was the handoff priority?
- Which prompt helped? What could you do without it?
- What did you leave out, and why?

Ask for evidence

- Observer: quote the owner and timing, noting any prompts.
- Receiver: what did you understand you were responsible for?
- Did the learner distinguish the earlier pain assessment from a response that was still unknown?

> ### Make the next step explicit
>
> Compare "Keep an eye on it" with "Can you reassess pain at 7:15 p.m. and confirm that you will take it?" What does each leave the receiver responsible for?

Documentation practice

Record the agreed task, owner, time and contingency. This confirms the handoff plan, not a completed reassessment or medication-order read-back.

Second attempt

Repeat with the same learner and options. Choose one target and record the retry in the second observer column.

Common difficulties

What you hear	What to explore
"The pain is better now."	Which reassessment supports that claim?
"Recheck it later."	Which time and which nurse?
"Okay" without confirmation	What did the receiver actually accept?

Later learners have prior exposure. Use an unfamiliar case to explore transfer; this retry is practice on a known task.

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FACULTY REFERENCE

Curriculum links

Suggested connections for lesson planning. These are limited mappings by the resource author, not endorsement, competency certification, or a validated scoring framework.

AACN Essentials

Domain 6, Interprofessional Partnerships, 6.1b: “Use various communication tools and techniques effectively.” Evidence here is the learner’s SBAR, clarification, and confirmation of responsibilities.

QSEN

Teamwork and Collaboration: explain the concern, clarify roles, and agree next steps. Safety: distinguish known findings from assumptions and communicate unresolved needs. Observe these behaviors; do not infer an entire competency from one exercise.

NCSBN Clinical Judgment Measurement Model

Recognize and analyze cues: distinguish the earlier pain score from the unknown medication response. Generate solutions and take action are represented only by communicating an existing care plan and transferring responsibility. This is limited clinical judgment practice; it does not test independent treatment selection or evaluation of the patient’s subsequent response.

A clearer second conversation demonstrates improvement on this familiar task. It does not by itself establish transfer to an unseen patient or completion of the clinical judgment cycle.

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SOURCES AND REUSE

Sources, review and reuse

Sources and related teaching resources

AACN Essentials: Domain 6: https://www.aacnnursing.org/essentials/tool-kit/domains-concepts/interprofessional-partnerships

QSEN: Prelicensure competencies: https://www.qsen.org/competencies-pre-licensure-ksas

NCSBN: Clinical Judgment Measurement Model: https://www.nclex.com/clinical-judgment-measurement-model.page

INACSL: Simulation standards and prebriefing: https://www.inacsl.org/healthcare-simulation-standards-of-best-practice-

AHRQ TeamSTEPPS: Handoff: https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/handoff.html

OpenStax: Pain assessment and reassessment: https://openstax.org/books/medical-surgical-nursing/pages/7-2-pain-assessment

SBAR authoring guide: bedside report, critical results, orders and read-back: https://medical.linguacopilot.in/guides/sbar-simulation-scenario-builder

Before you teach

Written by the Lingua CoPilot Medical team from the sources listed. These cases have not been clinically reviewed. The model answer is one possible response, not a standard of care.

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